

2000 067679

TICOR TITLE INSURANCE

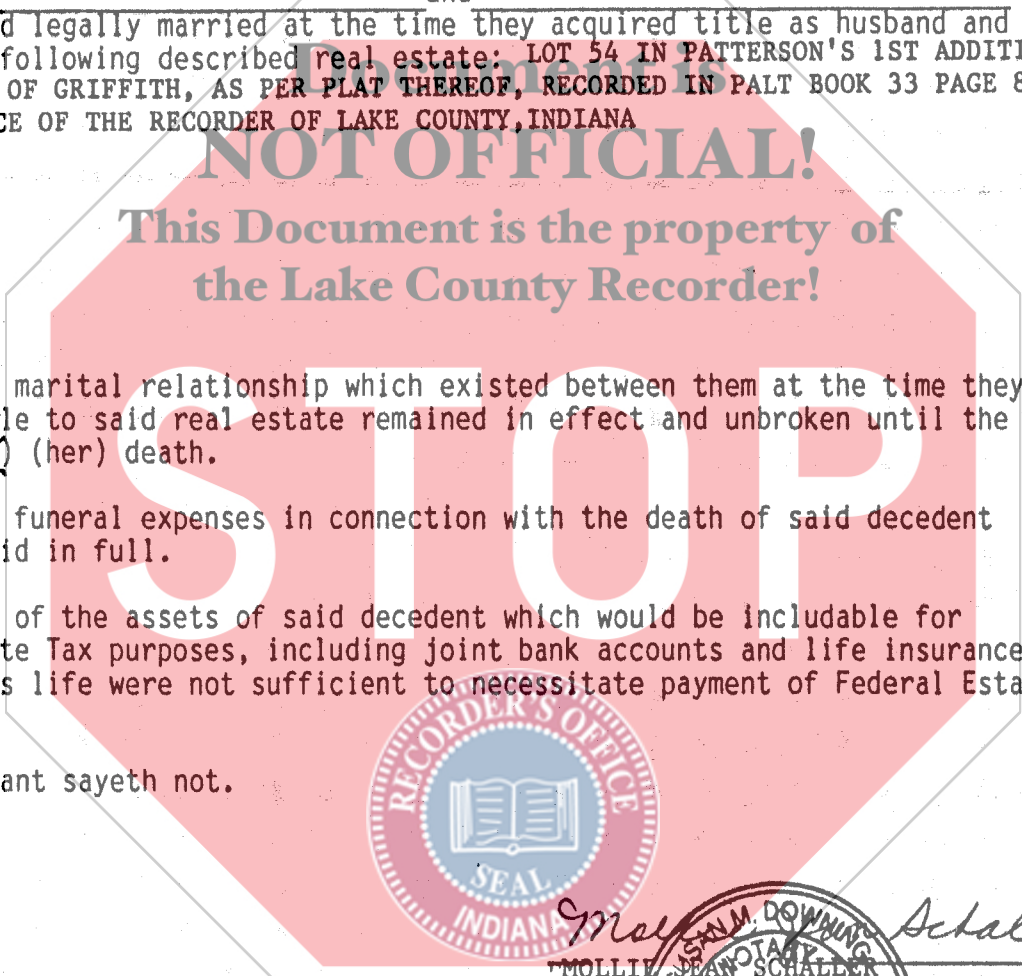
MORRIS W. CARTER
RECORDER

AFFIDAVIT

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

MOLLIE JEAN SCHALLER, being first duly
sworn upon oath, deposes and says:

1. That MOLLIE L. PIERCE died on Nov. 26, 1998 at Munster Indiana.
2. That EUGENE W. PIERCE and MOLLIE L. PIERCE were duly and legally married at the time they acquired title as husband and wife to the following described real estate: LOT 54 IN PATTERSON'S 1ST ADDITION TO THE TOWN OF GRIFFITH, AS PER PLAT THEREOF, RECORDED IN PALT BOOK 33 PAGE 80 IN THE OFFICE OF THE RECORDER OF LAKE COUNTY, INDIANA

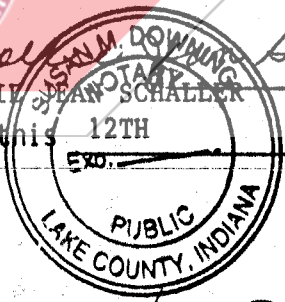


3. That the marital relationship which existed between them at the time they acquired title to said real estate remained in effect and unbroken until the date of ~~(his)~~ (her) death.
4. That all funeral expenses in connection with the death of said decedent have been paid in full.
5. That all of the assets of said decedent which would be includable for Federal Estate Tax purposes, including joint bank accounts and life insurance on decedent's life were not sufficient to necessitate payment of Federal Estate Tax.

Further affiant sayeth not.

92-4294 #10 Schman

Subscribed and sworn to before me, a Notary Public, this 12TH day of SEPTEMBER, 18 2000.



FILED

SEP 15 2000

PETER BENJAMIN M. DOWNING
LAKE COUNTY AUDITOR

My Commission expires:
4-10-07

County of Residence:

LAKE

This Instrument prepared by MOLLIE JEAN SCHALLER

00981

11.00
E.P.
T.

NOTATION: The Social Security # is requested by this state agency in order to fulfill its statutory responsibility. Disclosure is mandatory and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH
 CERTIFICATE OF DEATH

State No.

Local No. 2625-98

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-19-3

68205
 PE/PRINT
 IN
 PERMANENT
 LACK INK

1 DECEASED—NAME (First, Middle, Last) MOLLIE PIERCE		2 SEX FEMALE	3a TIME OF DEATH 11:20 A.M.	3b DATE OF DEATH (Month, Day, Yr) NOVEMBER 26, 1998	
4 SOCIAL SECURITY NUMBER 332-14-3677	5a AGE—Last Birthday (Years) 82	5b UNDER 1 YEAR Months Days	5c UNDER 1 DAY Hours Minutes	6 DATE OF BIRTH (Mo, Day, Yr) DEC. 20, 1915	
7 BIRTHPLACE (City and State or Foreign Country) DECATUR, IL.	8a PLACE OF DEATH (Check only one See instructions)				
8a WAS DECEDENT A U.S. VETERAN? NO	8b YEAR LAST SERVED IN U.S. ARMED FORCES? N/A	HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			
9a FACILITY NAME (If not institution, give street and number) THE COMMUNITY HOSPITAL		9b CITY, TOWN OR LOCATION OF DEATH MUNSTER	9c COUNTY OF DEATH LAKE		
10 MARITAL STATUS (Specify) MARRIED	11 SURVIVING SPOUSE (If wife, give maiden name) EUGENE PIERCE	12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) REGISTERED NURSE	12b KIND OF BUSINESS/INDUSTRY MEDICAL		
13a RESIDENCE—STATE INDIANA	13b COUNTY LAKE	13c CITY, TOWN OR LOCATION GRIFFITH	13d STREET AND NUMBER 728 N. GLENWOOD		
13e ZIP CODE 46319	13f INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	13g ON A FARM? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	14 CITIZEN OF WHAT COUNTRY? U.S.A.	15 WAS DECEDENT OF HISPANIC ORIGIN? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)	
16 RACE—American Indian, Black, White, etc. (Specify) WHITE		17 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) College (1-4 or 5+) 12 4			
18 FATHER'S NAME (First, Middle, Last) JOHN CHARLES GRACE		19 MOTHER'S NAME (First, Middle, Maiden Surname) PANSY SMITH			
20a INFORMANT'S NAME (Type/Print) EUGENE PIERCE		20b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 N. GLENWOOD GRIFFITH, IN. 46319	20c Relationship HUSBAND		
21a METHOD OF DISPOSITION <input type="checkbox"/> Entombment <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place) NOVEMBER 28, 1998 CALUMET PARK CEMETERY		21c LOCATION—City or Town, State MERRILLVILLE, IN.	
22a EMBALMER'S NAME HENRY BLAKE		22b EMBALMER'S LICENSE NO. FDO1019406	23 WAS DEATH REPORTED TO CORONER? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
24a SIGNATURE OF FUNERAL DIRECTOR		24b LICENSE NUMBER (of Licensee) FDO1006015	25 NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME FH8300275 FAGEN-MILLER FUNERAL HOMES 242 N. GRIFFITH BLVD. GRIFFITH, IN.		
26. PART I Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) <i>Coronary heart disease</i>		DUE TO (OR AS A CONSEQUENCE OF) <i>Myocardial infarction</i>			Approximate Interval Between Onset and Death <i>1.5 days</i>
Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last <i>Renal insufficiency</i>		DUE TO (OR AS A CONSEQUENCE OF) <i>Chronic kidney disease</i>			<i>70 days</i>
<i>NOV 30 1998</i>		<i>Arteriosclerotic cardiovascular disease</i>			<i>10 yrs</i>
PART II Other significant conditions - Conditions contributing to death but not previously stated in Part I					
<i>Arteriosclerotic cardiovascular disease</i>		27 WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) No	28a WAS AN AUTOPSY PERFORMED? (Yes or no) No	28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No	
29a CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge death occurred at the time, date and place and due to the cause(s) as stated <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation in my opinion, death occurred at the time, date, and place and due to the cause(s) as stated <input type="checkbox"/> CORONER On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place and due to the cause(s) and manner as stated		29b SIGNATURE AND TITLE OF CERTIFIER <i>Fred Adler M.D.</i>			
29c MEDICAL LICENSE NO. 01019251		29d DATE SIGNED (Month, Day, Year) 11/28, 1998			
30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 26) (Type/Print) FRED ADLER, M.D., 800 MACARTHUR BOULEVARD, MUNSTER, INDIANA 46321					
31 HEALTH OFFICER'S SIGNATURE <i>Fred Adler M.D.</i>		32 DATE FILED (Month, Day, Year) November 20, 1998			
33 MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		34a DATE OF INJURY (Month, Day, Year)	34b TIME OF INJURY	34c INJURY AT WORK? (Yes or no)	34d DESCRIBE HOW INJURY OCCURRED
34e PLACE OF INJURY—At home, farm, street, factory, office, building, etc. (Specify)		34f LOCATION (Street and Number or Rural Route Number, City or Town, State)			
34g DATE PRONOUNCED DEAD (Month, Day, Year)		34h MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.			

DECEDENT

PARENTS

FORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

Ochman W/0 92-5284